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New Initiatives and Approaches in Health Care Quality

The articles in this issue of the Health Care Financing Review *focus on innovations in measuring and improving the quality of health care services. Following are the abstracts for articles included in this issue. The* Review *may be ordered from the U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954. A one-year subscription is $30.00; single issues are $19.00. Click here to see a subscription form. For information on submitting articles to the* Review*, contact Linda Wolf, Editor-in-Chief, at (410) 786-6572 or by e-mail LWOLF@HCFA.GOV. Statements contained in* **Review** *articles are solely those of the authors and do not express any endorsement by the Health Care Financing Administration .*

Issues in Measuring and Improving Health Care Quality

Maria A. Friedman, D.B.A.

This issue of the *Health Care Financing Review* focuses on issues and advances in measuring and improving the quality of care, particularly for Medicare and Medicaid beneficiaries. Discussions of quality-related topics are especially timely, given the growing and widespread interest in improving quality in the organization, financing, and delivery of health care services. This article has several purposes. The first is provide a brief description of some of the causes underlying the growth of the care quality movement; the second is to provide a contextual framework for discussion of some of the overarching themes that emerge in this issue. These themes include examining conceptual issues, developing quality measures for specific sites and populations, and creating or adapting data sets for quality-measurement purposes.

Health Care Quality Improvement Program: A New Approach

Barbara J. Gagel, M.B.A.

The Health Care Financing Administration (HCFA) has embarked on a new program to ensure the quality of care provided to Medicare and Medicaid beneficiaries. The approach, entitled the Health Care Quality Improvement Program (HCQIP), focuses on improving the outcomes of care, measuring improvement, and surveying for patient satisfaction. HCQIP, still in its infancy, is undertaken in collaboration with the providers of care. This article describes HCQIP.

Toward a 21st Century Quality-Measurement System for Managed-Care Organizations

Rodney C. Armstead, M.D., Paul Elstein, Ph.D., and John Gorman

As the Nation's largest managed-care purchaser, the Health Care Financing Administration (HCFA) is working to develop a uniform data and performance-measurement system for all enrollees in managed-care plans. This effort will ultimately hold managed-care plans accountable for continuous improvement in the quality of care they provide and will provide information to consumers and purchasers to make responsible managed-care choices. This effort entails overhauling peer review organization (PRO) conduct of health maintenance organization (HMO) quality review, pilot testing a new HMO performance-measurement system, establishing criteria for Medicaid HMO quality-assurance (QA) programs, adapting employ-

ers' HMO performance reporting systems to the needs of Medicare and Medicaid, and participation in a new alliance between public and private sector managed-care purchasers to promote quality improvement and accountability for health plans.

Measuring Quality of Care Under Medicare and Medicaid

Stephen F. Jencks, M.D.

The Health Care Financing Administration's approach to measuring quality of care uses an accepted definition of quality, explicit domains of measurement, and a formal validation procedure that includes face validity, construct validity, reliability, clinical validation, and tests for usefulness. The indicators of quality for Medicare and Medicaid patients span the range of service types, medical conditions, and payment systems and rest on a variety of data systems. Some have already been incorporated into operational systems while others are scheduled for incorporation over the next 3 years.

Quality of Care in Teaching Nursing Homes: Findings and Implications

Peter W. Shaughnessy, Ph.D., Andrew M. Kramer, M.D., David F. Hittle, Ph.D., and John F. Steiner, M.D.

This article explores policy implications and selected methodological topics relating to long-term care (LTC) quality. We first discuss the Teaching Nursing Home Program (TNHP), in which quality of care in teaching nursing homes (TNHs) was found to be superior to the quality of care in comparison nursing homes (CNHs). A combination of outcome and process/structural measures was used to evaluate the effects of care and underlying reasons for superior TNH outcomes. Second, we explore policy and analytic ramifications. Conceptual, methodological, and applied issues in measuring and improving the quality of LTC are discussed in the context of TNH research and related research in home care.

Reconciling Practice and Theory: Challenges in Monitoring Medicaid Managed-Care Quality

Marsha Gold, Sc.D., and Suzanne Felt, M.P.A.

The massive shift to managed care in many State Medicaid programs heightens the importance of identifying effective approaches to promote and oversee quality in plans serving Medicaid enrollees. This article reviews operational issues and lessons from the ongoing evaluation of a three-State demonstration of the Health Care Financing Administration's Quality Assurance Reform Initiative (QARI) for Medicaid managed care. The QARI experience to date shows the potential utility of the system while drawing attention to the challenges involved in translating theory to practice. These challenges include data limitations and staffing constraints, diverse levels of sophistication among States and health plans, and the practical limitations of using quality indicators for a population that is often enrolled only on a discontinuous basis. To overcome these challenges, we suggest using realistically long time frames for system implementation, with intermediate short-term strategies that could treat States and managed-care plans differently depending on their stage of development.

Development and Testing of Nursing Home Quality Indicators

David R. Zimmerman, Ph.D., Sarita L. Karon, Ph.D., Greg Arling, Ph.D., Brenda Ryther Clark, R.N., M.S., Ted Collins, R.Ph., Richard Ross, and François Sainfort, Ph.D.

In this article, the authors report on the development and testing of a set of indicators of quality of care in nursing homes, using resident-level assessment data. These quality indicators (QIs) have been developed to provide a foundation for both external and internal quality-assurance (QA) and quality-improvement activities. The authors describe the development of the QIs, discuss their nature and characteristics, address the development of a QI-based quality-monitoring system (QMS), report on test of the QIs and the system, comment on methodological and current QI validation efforts, and conclude by raising further research and development issues.

A Data-Driven Approach to Improving Care of In-Center Hemodialysis Patients

William M. McClellan, M.D., M.P.H., Pamela R. Frederick, M.S.B., Steven D. Helgerson, M.D., M.P.H., Risa P. Hayes, Ph.D., David J. Ballard, M.D., Ph.D., and Michael McMullan, M.B.A.

Health care providers, patients, the end stage renal disease (ESRD) networks, and HCFA have developed the ESRD Health Care Quality Improvement Program (HCQIP) in an effort to assess and improve care provided to ESRD patients. Currently, the ESRD HCQIP focuses on quality indicators (QIs) for treatment of anemia, delivery of adequate dialysis, nutritional status, and blood-pressure control for adult in-center hemodialysis patients. QIs were measured in a national probability sample of ESRD patients, interventions and evaluations of the interventions are beginning. The ESRD HCQIP illustrates a way to mobilize the strengths of the public and private sectors to achieve improved care for special populations.

Florida's Medicaid AIDS Waiver: An Assessment of Dimensions of Quality

Marie E. Cowart, Dr.P.H., and Jean M. Mitchell, Ph.D.

Some State Medicaid agencies have implemented home and community-based waiver programs targeting acquired immunodeficiency syndrome (AIDS) patients. Under these initiatives, state Medicaid agencies can provide home and community-based services to persons with AIDS (PWA) as an alternative to more costly Medicaid-covered institutional care. This article evaluates quality of care under the Florida Medicaid waiver for PWA along two dimensions: program effectiveness and client satisfaction. Clients are really satisfied with their case managers and the range and availability of services. Case managers appear to be well trained. Moreover, the probability of turnover is quite low, despite heavy caseloads and high mortality. The major difficulty faced by clients and case managers relates to the process of becoming Medicaid eligible.

Surveying Consumer Satisfaction to Assess Managed-Care Quality: Current Practices

Marsha Gold, Sc.D., and Judith Wooldridge, M.A.

Growing interest in using consumer satisfaction information to enhance quality of care and promote informed consumer choice has accompanied recent expansions in managed care. This article synthesizes information about consumer satisfaction surveys conducted by man-

aged-care plans, government and other agencies, community groups, and purchasers of care. We discuss survey content, methods, and use of consumer survey information. Differences in the use of consumer surveys preclude one instrument or methodology from meeting all needs. The effectiveness of plan-based surveys could be enhanced by increased information on alternative survey instruments and methods and new methodological studies, such as ones developing risk-adjustment methods.

Medicare Beneficiaries Rate Their Medical Care: New Data From the MCBS

Gerald S. Adler, M.Phil.

The Medicare Current Beneficiary Survey (MCBS) contains a wealth of information about the people whose care is financed by the program. This article examines their satisfaction with medical care received and explores the relationship of these attitudes with the characteristics of subgroups of the enrolled population. Satisfaction with medical care among Medicare beneficiaries is found to be generally high (80-90 percent). Disabled Medicare beneficiaries are less satisfied than the aged, and health maintenance organization (HMO) enrollees less satisfied than fee-for-service (FFS) patients. Others with lower-than-average satisfaction are people with poorer health status, those covered by Medicaid, and those without supplementary insurance.

Agreement Between Physicians' Office Records and Medicare Part B Claims Data
Jinnet B. Fowles, Ph.D., Ann G. Lawthers, Sc.D., Jonathan P. Weiner, Dr.P.H., Deborah W. Garnick, Sc.D., Doris S. Petrie, and R.Heather Palmer, M.B., B.Ch., S.M.

This article tests agreement between demographic, diagnostic, and procedural information from primary-care physicians' office records and Medicare Part B claims for Maryland Medicare beneficiaries. The extent of agreement depended on the category of information being compared. Demographics matched poorly, probably due to incomplete record samples. Important diagnoses were often missing from the medical record. When claims indicated the presence of disease, the patient was likely to have the disease, but claims did not capture all people who have the disease. Additionally, many laboratory tests and procedures were missing from the primary-care record. The appropriate use of either of these data sources depends on the specific research question that is being asked.

Impacts of Hospital Budget Limits in Rochester, New York

Bernard Friedman, Ph.D., and Herbert S. Wong, Ph.D.

During 1980-87, eight hospitals in the Rochester, New York area participated in an experimental program to limit total revenue. This article analyzes: increase of costs for Rochester hospitals; trends for input and compensation; and cash flow margins. Real expense per case grew annually by about 3 percent less in Rochester. However, after 1984, Medicare prospective payment had an effect of similar size outside Rochester. Some capital inputs were restrained, as were wages and particularly benefit program did not generally raise or stabilize hospital revenue margins, while the ratio of cash flow to debt trended down. Financial stringency of this program relative to alternatives may have contributed to its end.

DataView: National Health Expenditure Projections, 1994-2005

Sally T. Burner and Daniel R. Waldo

Using 1993 as a baseline and assuming that current laws and practices continue, the authors project U.S. health expenditures through the year 2005. Annual spending growth has declined since 1990, and, in the scenario reported here, that trend continues in 1994. Growth of health spending increases thereafter, but remains below the average experience of the past decade. Even so, health expenditures grow faster than the gross domestic product (GDP), and by 2005, account for 17.9 percent of the GDP. Unless the system changes, Medicare and Medicaid are projected to pay for an increasing share of total spending during the next decade.